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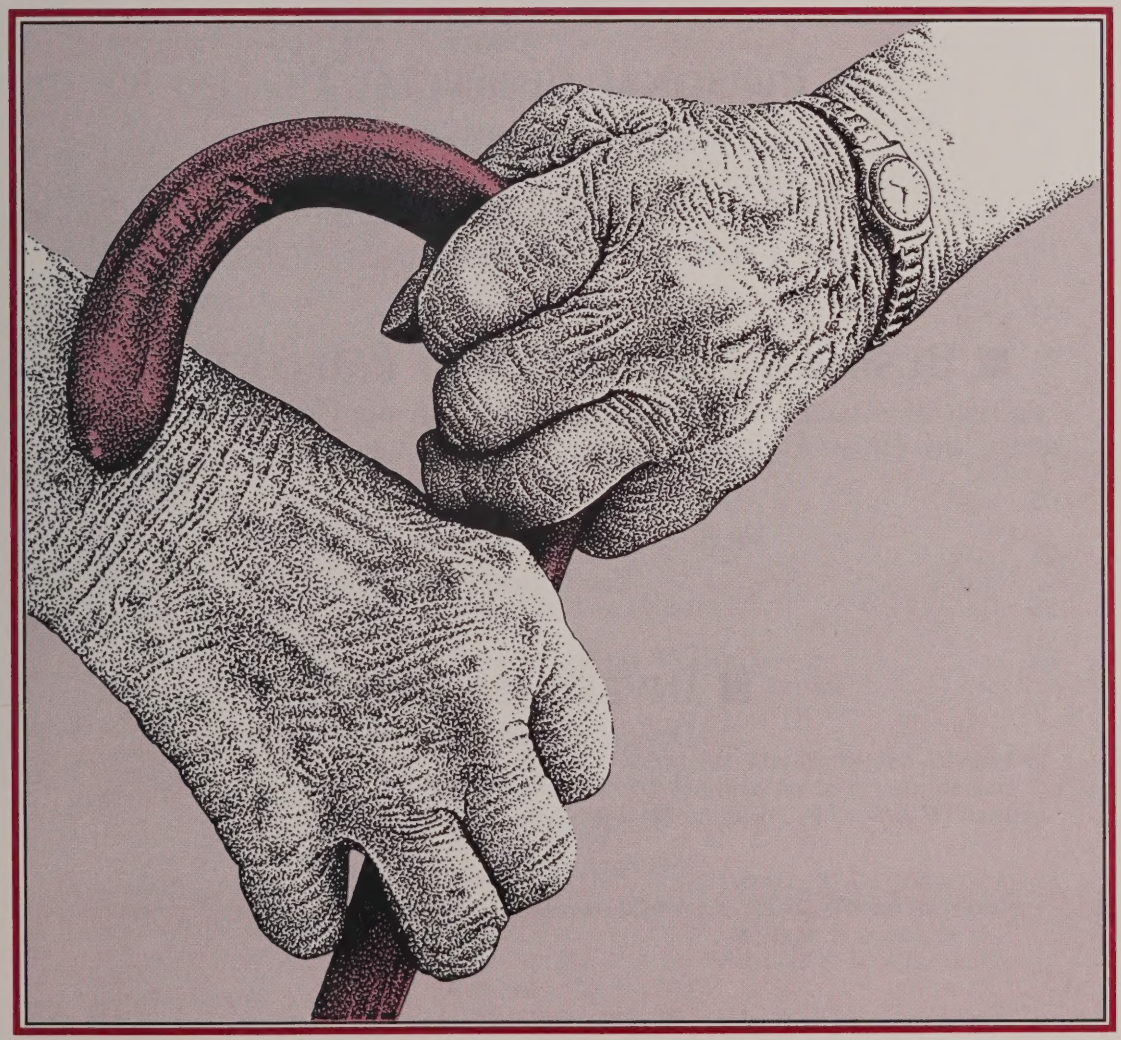

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THE
Hampden Hippocrat
NOVEMBER-DECEMBER 1994

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The official bulletin for The Hampden District of the Massachusetts Medical Society. Founded in 1942 by Edward P. Bagg, Jr., M.D. and William A. R. Chapin, M.D.

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HAMPDEN DISTRICT MEDICAL SOCIETY 1994-1995 SEASON

DISTRICT MEETING

PLACE: **SHERATON SPRINGFIELD**
Monarch Place Hotel
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DATE: Tuesday, January 24, 1995

BUSINESS MEETING: 6:00 p.m.

SOCIAL HOUR: 7:00 p.m.

DINNER: 7:30 p.m., SPOUSES ARE WELCOME!

SPEAKER: Lonnie R. Bristow, M.D.
President-Elect, American Medical Association

SUBJECT: AMA Reports On The Issues

NOTE: If you must cancel your dinner reservation, please call the HDMS office before noon on January 24th. If the cancellation is not made, you will be BILLED for your dinner.

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Baystate Medical Center Children's Hospital is happy to welcome **Paul S. Salva, M.D., Ph.D.,** pediatric pulmonologist, back to the community.

A native of Enfield, CT, Dr. Salva has specialized training in pediatric lung diseases (including asthma, cystic fibrosis, bronchopulmonary dysplasia and intensive care). A graduate of Holy Cross College, he earned his Ph.D. in medicinal chemistry at the University of Connecticut, and his M.D. at Texas Tech University. He completed his residency and fellowship at two nationally recognized centers for pediatric lung disease: The University of Arizona and Riley Children's Hospital in Indianapolis.

Baystate Medical Education & Research Foundation

The author of numerous research papers and a book chapter on infant pneumonias, Dr. Salva is a Fellow of the American Academy of Pediatrics and a member of the American Thoracic Society.

To schedule an appointment, please call 784-5055.

From The Editor

This issue of the Hampden Hippocrat covers an inter-disciplinary subject–the presentation of post polio syndrome. This is a current interest of the Public Health Committee and Dr. Francis Riley and Dr. Dennis Gordon have worked on the articles.

Dr. Michael Rosen has also given us a review of the philosophical and pragmatic considerations in the practice of "Palliative Medicine". This is a manner of practice that some will say has long been known, but is certainly becoming more formalized.

A summary is included of the address Dr. Irwin Kuzmarov gave at the fall meeting on the Canadian Health Care System. This single payer system enjoys widespread public support as an option in Hampden County. Some prognosticators would argue that it is the system of the future here in the U.S.

Dr. Tony Dores has graciously submitted a farewell to his old friend Dr. Pedro Silva.

I wish you the happiest of holidays and enthusiasm and fulfillment for the new year to come.

Brigid Glackin, M.D.
Editor

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Plainly Speaking

I recently heard a lament from a nurse: 'Why can't doctors talk to their patients?' When I asked her to elaborate, she said that she had been approached by a patient who had just seen her doctor. The patient did not understand what she had been told and was too embarrassed to ask the doctor for an explanation. This lady had many unanswered questions and she wanted help from the nurse.

Alicia O. M. Ross, M.D., President

I have recently seen a patient in referral for management of breast cancer. Two years before the diagnosis was made she had an abnormal mammogram but never followed it up. Detailed questioning brought out the fact that she did not understand the seriousness of those findings.

Patients want to know what's happening but are frequently afraid to ask. When the problem is very serious it is often better to talk with them in the presence of a trusted family member or friend. It is also a good idea to advise patients to write down questions as they think of them and to bring them up at the next appointment.

Just this week I was called to see a patient with a diagnosis of a probable malignant lymphoma. The patient and spouse were told that I was scheduled for a visit but were not told why. They spent several days prior to the appointment in agonizing speculation about why an oncologist was involved. A simple explanation could have saved them much anguish.

The importance of communications was impressed upon me yesterday by a patient with chronic lymphocytic leukemia. Four years ago when he was initially diagnosed, we explained to the patient and his wife the different possibilities that can occur with this disease. Now he is at the point where he is experiencing some complications. The patient's wife called after he recovered from a particularly bad episode to tell me how grateful she was for those earlier explanations about his illness. This has helped her to be emotionally prepared for the difficult times ahead, and for the family to settle some legal matters and other business.

Just as we want to know our own diagnoses, so our patients want to be told about theirs in language that they can understand. ■

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A Time That Was Forgotten

Sometimes, I feel like a live relic of the 1930s and 40s, both without infantile paralysis and before polio vaccine. At any rate, I can vouch for the authenticity of Mr. Carroll H. Dwyer, III's impressive, little essay on the delayed consequences of survival from paralytic poliomyelitis. I commend him for his evangelistic approach to the cause, which, I believe, may be ultimately best served by such a layman.

Francis J. Riley, M.D.
Chairman
Public Health Committee

Do you remember those long hot steamy summers of years gone by? The days of ice cream and a cool dip in the lake or pool would satisfy you. The times we played in the rain during a summer shower.

Do you remember the fear of that time, when everyone feared the polio virus? There was someone you knew or some relative that caught the polio virus that summer or fall.

In some cases people would die from this disease. With others polio would change their lives forever. They would be subject to many hardships, long stays in the hospital and long hours of therapy to help strengthen weak muscles. Some would not have visitors at all for many reasons.

The polio virus would attack the body's central nervous system and do damage to muscle in all parts of the body. Some people would gain by use of these affected areas. In 1956 the polio vaccine was discovered which slowed down the epidemics of the 1950s. Then in 1961 the oral vaccine came out to put the end to polio in this country today.

Now some 30 to 40 years after surviving this killing and crippling disease, polio survivors have to face this ghost from the past, again alone. There is no more March of Dimes nor The Polio Foundation from those days long ago.

What the survivor has to face is the late effects from polio, which is called Post Polio Syndrome. Some of the problems are weakness and fatigue in muscles, breathing and swallowing difficulties and sleeping disorders, just to name a few.

What is needed is an awareness. Polio survivors must be found and educated. The doctors of today must also be educated, for they do not have the experience concerning this forgotten disease. There are not very many doctors or hospitals that are dealing with Post Polio.

The polio virus would attack the body's central nervous system and do damage to muscle in all parts of the body.

So we stand alone as forgotten heroes. We fought like warriors in those battles to overcome what life had handed us. Our scars and braces are our medals. We ask for nothing but a chance to live with pride and understanding.

Now many of us are over 40 years old, looking at this enemy from the past. We do not know what is happening to our bodies nor who to go to to find the answers to our dilemma.

There are still many polio survivors out there, lost like I was. So I have decided to bring this subject out to the masses. To let them know that they are not alone facing these late effects called Post Polio. We must unite together to fight again this enemy from the past as forgotten heroes.

Carroll H. Dwyer, III
Polio Survivor

Late Sequelae of Polio

By the time I was graduated from high school in 1963, polio had come only as close as an elementary school classmate with a slightly drooping shoulder, and receiving Salk vaccine in third grade. Medical school brought only glimpses of empty "Drinkers" (iron lungs) in the basements of hospitals. Anyone younger (and that includes the majority of practicing physicians) probably has no memory more pungent than oral polio

vaccine on sugar. Now, that unfamiliar disease is back for round two.

Patients who survived a bout of paralytic polio, including my classmate, recovered function through effort and exercise. They provided training to countless physical and occupational therapists and characterized rehabilitation for years. Their progress was measured by objective increases in strength as well as decreasing use of assistive devices. These patients became, to a disproportionate extent, goal oriented achievers. Thirty or so years later, they are in physicians' offices because things are not going well, and they wonder if they are having a recurrence.

Although late sequelae of polio had been described in the last century, our present consciousness of post polio syndrome (PPS) or sequelae is a rediscovered one based on a growing experience with the several hundred thousand survivors of polio of the 1940s and 1950s. That experience, however, is not one that individual physicians are likely to have, since physicians outnumber patients. It is important that we nevertheless add PPS to the differential diagnosis of patients presenting with vague or specific fatigue, weakness, pain, breathing problems, vasomotor symptoms or dysphagia. Earlier patients were done a disservice by being told they might have a kind of ALS, recurrent polio, or other horror stories. By now, neurologists should be able to reach the correct conclusion with a minimum of patient stress.

Difficulty arises because what we have to tell these patients is not what they are used to hearing. That is, more hard work on their part may be useless or, indeed, harmful, in that exercise may accelerate their strength loss.

Although some questions remain, it appears that what has happened in PPS is not a new episode of some disease. Rather, at the time of the acute polio episode, muscle fibers became denervated by loss of the corresponding anterior horn cells, (AHC). Recovery depended on at least two processes: 1) Hypertrophy of remaining, normally innervated muscle fibers and 2) Sprouting of axons from surviving anterior horn cells so that those cells established contact with dying, denervated muscle fibers and in effect, adopted them. Although a percentage of nerve fibers was lost in any muscle, the eventual case was that of a reduced number of AHCs innervating any muscle, but each AHC responsible for a larger number of muscle fibers, each muscle fiber survivor being somewhat larger than it used to be. A motor unit (AHC, axon, and innervated muscle fibers) in a recovered muscle was thus large compared with

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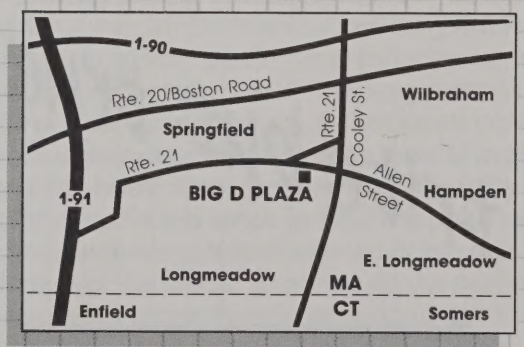

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its premorbid state. The electromyogram, recording the potentials generated by a depolarizing motor unit, could thus detect huge potentials, on the order of fifty times the size of the normal smallest potential, in the muscles of recovered polio patients. This reflects a still quite functional situation. With time, however, AHCs slowly die. If there is a normal complement of AHCs to a muscle, the loss of any one AHC would have little effect. In the post polio patient, however, a muscle could have in extreme cases, only a few AHCs, the loss of any one of which would weaken the muscle noticeably. Once the patient is hanging on to functionality with a barely antigravity leg muscle served by, e.g., 5 AHCs, the loss of one of those AHCs will render the patient non-ambulatory.

Corollary to the situation where a patient is just barely functional is the fact that, at that point, everyday-activity is probably maximum exertion, and attempts to strengthen the muscle with exercise will simply lead to fatigue quicker. Support for this general statement is found in those patients whose diaphragms are affected. Resting the diaphragm with nighttime ventilator support has been shown to increase the diaphragm's strength. Nevertheless, non-fatiguing, aerobic exercise has been beneficial to patients. Of course, since we are dealing with people who have longstanding faith that more exercise is always better, restraint is the more difficult lesson.

If the message that less exercise is better is difficult for patients to accept, the idea that one might have to go back to using assistive devices that were discarded years ago is one that almost certainly triggers denial. While the psychological damage of recurrent disability can be countered with counseling, aimed at devaluing the physical aspects of self worth, and support group activity, this is more difficult in PPS because these patients experience not a single decrement in function, but ongoing worsening. While timely referral for rehabilitation interventions can prolong independence, patients who repeatedly require such help can become increasingly discouraged. Fortunately, these patients often have an unexpected resilience, possibly trained into them from their acute polio experience, that helps them through these difficulties. ■

Dennis S. Gordan, M.D.
Medical Director
Weldon Center for Rehabilitation
Mercy Hospital

Hampden Committee Activities

The Public Health Committee met in September and October. Mr. Carroll Dwyer, who suffers from Post Polio Syndrome, was the guest speaker at the September meeting. Mr. Dwyer stressed the importance of proper diagnosis of this disease. He is trying to bring awareness of it to both patients and physicians. Mr. Dwyer wrote an article on post polio syndrome which will be featured in our next issue. The committee discussed the Seat Belt Question at their October meeting. It was decided that a press release in favor of seat belts should be worked up and generated before the November 8th ballot.

The Executive Committee met in September and October. Reports were given on the various activities being sponsored by Hampden District and Mass Medical.

The House Calls program held on September 18, 1994 featured the topic of Prostate Disease. The program was quite a success with 15 physicians answering questions from the public live from 7:00 to 8:00 p.m. and for two hours following.

80 members, spouses, and guests attended our District Meeting on October 4, 1994 at Betty's Old Towne House in Agawam. Dr. Harry Greene, the new Executive Vice-President of MMS, spoke at our business meeting. Dr. Irwin Kuzmarov, a urologist from Canada, spoke at the dinner portion of the meeting on the Canadian Health Care System. Also, Dr. William Baker was honored for his many years of service as a delegate to the MMS and as an editor of the Hampden Hippocrat.

Dr. Gopal Malladi, the chair for this year's Doctor-For-A-Day, reported that 16 "interns" from the business community spent the day with 32 physicians. As always, the program was a huge success.

Our 10th Annual Medical Ethics Seminar was held at Mercy Hospital's Deliso Center on October 19, 1994. 185 health care professionals attended to hear Professor Arthur Dyck, of the Harvard School of Public Health, speak on the topic of assisted suicide. The panel consisted of Rev. Bruce Benander, Attorney Ted Brown, Beth Drummond, R.N., Rabbi Jerome Gurland, and Robert Kasper, M.D. The evaluations received have been very positive.

The Medico-Legal Committee sponsored their 3rd Annual Dinner Forum on November 3, 1994 at the Delaney House in Holyoke. Over 100 hundred physicians, lawyers, and their guests had the opportunity to watch a "mock" medical malpractice tribunal. Participants for the evening were Superior Court Judge Constance Sweeney, Dr. Mark Mullan, and Attorneys John Bagley, Bob Gelinas, Melinda Phelps, and Phyllis Ryan. The program was very informative and everyone in attendance had a wonderful time. ■

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Palliative Medicine-A Review Of The Field

by Michael Rosen, M.D.

Dr. Rosen is a medical oncologist in practice with Springfield Medical Associates. He is also medical director of Pioneer Valley Hospice

When approaching the daunting task of reviewing the broad and expanding field of palliative medicine, it may be best to start with basics and review definitions. The World Health Organization defines Palliative Medicine as "the active total care of patients whose disease is not responsive to curative treatment. Control of pain, of other symptoms and of psychological, social and spiritual problems is paramount. The goal of palliative care is achievement of the best quality of life for patients and their families." "Many aspects of palliative care are also applicable earlier in the course of the illness in conjunction with anti-cancer treatment... Palliative care... affirms life and regards dying as a normal process... neither hastens nor postpones death... provides relief from pain and other distressing symptoms... integrates the psychological and the spiritual aspects of care... offers a support system to help patients live as actively as possible until death... offers a support system to help the family cope during the patient's illness and in their own bereavement."

The goal of palliative care is achievement of the best quality of life for patients and their families.

When palliative medicine was recognized as a medical specialty in Great Britain in 1987, it was defined as "the study and management of patients with active, progressive, far-advanced disease for whom the prognosis is limited and the focus of care is the quality of life".

These statements crystallize a number of basic principles which we recognize as essential to the spirit of palliative medicine. The word terminal did not appear in these definitions because it may be seen as limiting the benefits of this approach to debilitated patients in the last stages of life. When are patients "terminal"? Are "terminal" patients eligible for palliative care only in the last hours, days, weeks or months? Does the magical six months enter into the calculus? From the pragmatic perspective of palliative medicine, patient, family and physicians simultaneously select a palliative approach and recognize the terminal nature of a disease state by selecting comfort and quality of life as the paramount concern. The twentieth century has witnessed dramatic transformation in medical practice. Physicians at the turn of the century had little to offer their patients but hand holding and house calls. At the dawn of the twenty-first century the battleground of medicine is shifting to the molecular level of disease. By recognizing the inevitability of death and its natural role in the cycle of life, we aren't rejecting the advances of this century but trying to place them in perspective. Many physicians whose careers have encompassed these changes look with dismay upon a branch of medicine which seems to turn its back on progress and find its inspiration in an earlier pre-scientific area. I hope, by presenting two cases in which the principles of modern palliative medicine are applied, to demonstrate that palliative medicine attempts to synthesize the best of both eras: high science and warm humanity.

Case #1–Three Is a Crowd

Mrs. Martin is a 75-year old widowed seamstress with three daughters who develops severe back pain 10 years after her mastectomy. Her primary practitioner performs a bone scan which confirms the clinical suspicion of metastatic bone

disease. The patient is referred to a medical oncologist who is advised by the oldest daughter in confidence prior to the visit that "Mom can't handle it. Explain everything to me. I'll take care of the rest. She'll be the perfect patient". The physician emphasizes that his primary responsibility is to the patient and that all other relationships serve the primary one. He reassures the family that the patient will be given honest but hopefully sympathetic answers to all of her questions with keen attention paid to the patient's stated desire for information.

Directly or subtly, the vast majority of patients will make clear how much information they wish to have. Invariably, the patient is equipped to handle the requested information. Conversely, the patient should not be burdened with information if she makes it clear that she doesn't want it. Physicians ignore such direction at their own peril. Families must be reassured that the patient will be given honest but hopefully sympathetic answers to all of her questions with keen attention paid to the patient's stated desire for information. However, if a sympathetic review of these basic principles does not ally the concerns of the family, I believe the physician should emphasize the availability of other practitioners who might be more amenable to direction.

Once the physician evaluates Mrs. Martin, everyone is shocked by the direct questions posed by Mrs. Martin. "How long have I got, doc? What are the goals of treatment? Will I just suffer longer?"

The first interview should set the tone for the patient, family and physician relationship. For incurable diseases, the patient should be advised that palliative care (enhancement of quality rather than quantity of life) is the goal of therapy. Treatments may be very aggressive up to and including intensive chemotherapy, but if palliation of symptoms is emphasized at the outset, the subsequent transition to less aggressive modalities will be gentle and natural.

Discussion of survival must balance two conflicting motives. First, patients are entitled to an honest appraisal so that they can appropriately expedite their affairs. Simultaneously, a hopeful approach is mandatory to enhance quality of life in the here and now. Both goals may be met by explaining the statistical principle of median survival. Mrs. Martin may be told that for 1000 patients we might expect a median survival of two years. For such a large group we would

Continued on next page

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Palliative Medicine

Continued from previous page

expect that half would survive less and half would survive for more than two years. Some might even survive decades, as we have all observed in this disorder. By recruiting the uncertainty principle, the physician may actually be stimulating an unexpected degree of optimism in an otherwise grim discussion. Parenthetically, an unexpected opportunity for humor may arise in this discussion. At this point in the interview I have often reflected on the cultural preparation that the popular media have offered for this discussion. "I grew up on soap operas." I might observe. "Typically a perfectly healthy, young woman returns from her doctor's visit to inform her husband that she now has six months to live. She then spends the next six months racing from one love affair to the next with the final resolution at exactly six months being an unexpected, dramatic remission or tragically, transmigration to a competing program. All the while the beautiful, young heroine hasn't had a hair out of place let alone complete alopecia from chemotherapy." My mnemonic for this encounter is **HUSHH**. Instead of the silence of a bygone era. **H**onesty, **U**ncertainty, **S**ympathy, **H**ope and **H**umor may mitigate the devastating impact of this encounter. ■

The specific therapies are discussed with Mrs. Martin and her daughters. Active anti-neoplastic therapy with radiation and Tamoxifen generally elicits enthusiasm, but discussion of narcotic analgesics may provoke dismay. At the phrase "morphine sulfate", patient and daughters gasp. "Isn't that addictive? Will it work when I really need it? I really don't have a prayer, do I, doc?

Honest scientific information is the best way to address fear of narcotics. Without a past history of substance abuse, the risk of addiction is nil. In comprehensive review of over 10,000 patients with severe burns treated with narcotic analgesics, less than 1% of those without previous substance abuse history will become narcotic-dependent. At a deeper level, Mrs. Martin raises the fear of drug dependence as a way of probing her terminal status. She is looking for reassurance that her humanity has in no way been diminished by terminal disease. By emphasizing that optimal analgesia is safe as well as effective, the physician confirms that all the usual rules of medical practice still apply; she understands that she is not

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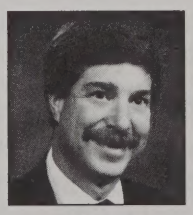

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being brushed off as "terminal", i.e. fit for euthanasia.

Dr. Thomas Preston, in his op-ed piece for **The New York Times** on November 1, 1994, declares that "the morphine drip is undeniably euthanasia..." He goes on to note that "euthanasia is widespread now." If a Professor of Medicine at the University of Washington is so blatantly ignorant of basic principles, we cannot expect our patients to gladly accept narcotic analgesics without serious reservations.

Patients and families must be reassured that tolerance to medication, although an observed phenomenon, is rarely a major obstacle to effective relief of pain. The Puritan influence often prompts our patients to delay effective analgesia in a desire to "save" effective pain relief for the bleak time at the end when it is "really necessary." The physician must work hard with patient and family to emphasize that effective analgesia will have its most dramatic impact when the patient is physically more capable of activity, allowing greater enjoyment of life's pleasures. With the progression of disease, doses of analgesics often need to be increased, but good pain relief will still be achieved in over 90% of patients right through to the time of death. The best teacher for both physician and patient is experience. After the physician becomes accustomed to seeing patients transformed from shut-ins to active participants in life by virtue of pain control, he or she is capable of transmitting enthusiasm for the life-enhancing properties of Morpheus to his patients. By the same token, after the patient has experienced a degree of relief, she will become an active participant in the design of the individualized palliative program.

Case #2-Heavy Breathing

Mr. Jones is an 83-year old retired plumber with a long smoking history and end-stage pulmonary disease. He has been on and off the respirator four times with progressive debilitation noted after each encounter with intensive care technology. After Mr. Jones decides that he would rather die than go on a respirator again, Dr. Heinz suggests that he consider support from the local hospice program. After a standard home evaluation by a nurse and social worker with patient and family over an afternoon, an overall care plan must be designed to effectively address likely symptoms as they develop at home. Dr. Heinz has been Mr. Jones's pulmonologist and primary care physician for 10 years

Continued on next page

ATTENTION PHYSICIANS:

On July 18, 1994 the Mass. Medical Society's Executive Brief issued the following statement in regards to Healthcare Networks of America, Inc.

CAUTION URGED ON SOLICITATIONS

Several MMS members have notified Society headquarters of recent solicitations from the *Healthcare Networks of America, Inc. (HNA)* The organization has approached Massachusetts physicians with the opportunity to become an HNA member (as described in the solicitation letter) "to be the recipients of the patients HNA generates through its marketing programs and contracts." As noted in a December 1993 edition of the *Executive Brief*, the American Medical Association encourages physicians, before making any commitment, to obtain as much information as possible about HNA activities. It may be helpful to request a list of the organization's payor contracts or names of member physicians to contact as references. For more information, physicians should consult their attorneys or can contact the AMA Health Law Division at (312) 464-5000. ■

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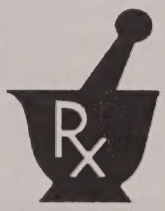

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Palliative Medicine

Continued from previous page

and completely supports Mr. Jones's decision to eschew aggressive therapy in favor of comfort care at home. A careful plan of care is reviewed with Dr. Heinz: physical therapy to maximize mobility, nutritional planning, bowel regimen, spiritual care, home health aide support are organized in detail–the full spectrum of human activity from sublime to mundane. Patient and family then pose the most terrifying question of all. "What will I do when I can't breathe? What will you do for me when I call?" The hospice nurse addresses this concern to Dr. Heinz soliciting his opinion on the advisability of morphine sulfate for the relief of intractable dyspnea. Dr. Heinz, heretofore the model enlightened physician, bristles visibly and informs the hospice nurse that euthanasia is against the law and that if she wants morphine for her patient, she had better call a certain pathologist residing in Michigan.

No other medical situation better illustrates the necessity of education in the promulgation of basic principles of palliative medicine. Careful studies for over 20 years have demonstrated that the administration of morphine sulfate can relieve dyspnea from lung and heart disease without hastening death (excepting patients in the immediate postoperative period). Patients with advanced pulmonary disease have an average 18% improvement in treadmill work performance after a single oral dose of morphine sulfate. Morphine sulfate is not a panacea for intractable dyspnea, but all of our science demonstrates that is isn't euthanasia either. As demonstrated by Eduardo Bruera at the University of Alberta, morphine sulfate enhances comfort and activity level in dyspneic patients without hastening death. When morphine is administered to dyspneic ambulatory patients as part of an integrated palliative effort, transformation from terrified shut-in to animated participant in the joys of life is observed so regularly as to become commonplace. An enlightened approach to the incorporation of morphine for the control of intractable dyspnea in terminal patients is a fact of life in modern palliative care.

At this point, it is worthwhile to note that discussion of euthanasia and assisted suicide is out of place in a review of palliative medicine. Measures which were once widely accepted as indispensable in the appropriate care of dying patients such as parenteral nutrition, intravenous hydration and mechanical ventilation are now seen as unproven invasions and abusive indignities inflicted on the dying. Patients survive for weeks with minimal oral intake and with good control of symptoms utilizing parenteral analgesics. As a house officer, I thought that intravenous hydration with simultaneous pulmonary edema during the last weeks of life were part and parcel of the dying process. Little did I realize that many of the "typical" manifestations of the dying process were the consequences of my well-intentioned efforts to ease pain and suffering. If we control pain, dyspnea, constipation and other typical symptoms with effective, non-invasive measures, we will eliminate the need to consider euthanasia and assisted suicides. Let the lawyers and politicians argue about euthanasia and provide legal means for the rare individuals to obtain this service at the hands of trained non-medical technicians if this is the public will. Let the physicians heal and bring comfort.

The challenge to the burgeoning specialty of palliative medicine is to translate the principles demonstrated in small inpatient units to large outpatient palliative care programs. Without development of active academic palliative care programs, these studies will never be done and individual palliative care physicians will remain voices in the wilderness. Palliative medicine doesn't aim to turn the clock back to a pre-scientific medical era. By simultaneously offering the best quality of life to our patients while we gather desperately needed data, we will irresistibly compel the medical community to incorporate the principles of palliative medicine into their everyday practice. ■

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Doctor Pedro Silva–In Memoriam

Dr. Pedro Silva was born in Lisbon, Portugal in 1934. He lived and studied in his city until he graduated from medical school in 1959. That same year he met and married his great and only love in live, Karin, with whom he left for Germany, to work in an American Medical Institution.

In 1961 he came to the United States, and after serving two years of internship at the Robert Packer Hospital (Guthrie Clinic) in PA, he moved to Springfield where he completed his specialty of OB/GYN, and where later he established his private practice and his home.

I had the luck to meet him in Worcester in 1967, and as it did happen with so many others, soon we became very good friends.

To me, as to so many others, he was the friend who always was there; touching, understanding, unselfish, ready to give and who felt fulfilled when others were happy and successful.

Unfortunately Pedro left us, after much suffering. But for his family and friends, and anyone who had contact with him, his image, natural love, and devotion will last forever! He will always be the friend our heart will remember, when searching for a man, who only knew how to give and only learned how to feel rewarded, to his satisfaction, when seeing others happy. ■

Antonio Dores, M.D.

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The Current Status Of The Canadian Health Care System vs Clinton Health Care Reform

Dr. Irwin Kuzmarov, a urologist from Pointe Claire, Quebec, addressed the Hampden District Medical Society at the fall meeting, October 5, 1994. He is former president of the Quebec Urological Association. A synopsis of his remarks is given below.

The federal government of Canada has no involvement in the day to day activities of the family doctor, as those activities involve the patient and the hospital. It's the provinces that have to deal with those issues. The provinces have several different departments that get involved in health care. The Ministries of Education deal with residents' training. The Clinton plan talks of controlling numbers and ratios of family doctors to specialists. These are realities that are controlled in Canada through the Ministries of Education and their budgets to the universities. The Treasury Board determines the amounts of money and where money will be injected into the system. The Ministries of Social Affairs or Health in the various provinces control the programs that have to do with social welfare, including the universal health care program which is called Medicare. When people talk about administrative costs in the Canadian Health Care System, it's a misrepresentation, because there are monies that are required to administer the program that you don't see, because, it's spread over the budget of several agencies.

The Canadian Health Act is the fundamental rules under which Canada's health care program works. The Act requires that the health care program be publicly administered and it has to be universal, portable and accessible. The fact of public administration is interesting because it means the politician is directly responsible at election time for the system. The system of Canadian health care is capitated at the hospital end with restrictions on hospitals' budgets and growth. It's a "fee for service predominant" system. The freedom to choose a practitioner and a specialist in Canada is totally unlimited, in comparison to Britain. I feel the absence of a gatekeeper is the key to a successful system.

Compared to other nations, Canada spends a lot on health care relative to other countries, but not as much as the United States.

The Canadian system is a socialized one–we have to accept it. The gravy days are over in Canada. They're probably over in the United States. Socialized medicine produces a diminution in the role of the physician in the control and direction of health care. The physician becomes a member of one of several competing groups that vie for control. Those who could not adjust to the Canadian system left for the United States only to begin to see these problems emerging there. When health care becomes a right, there ain't no place to escape.

Compared to other nations, Canada spends a lot on health care relative to other countries , but not as much as the United States. In 1989, this represented 9% of per capita income. It's projected to be 20% by the year 2000. The Canadian plan was conceived in an altruistic climate with its main aim to provide universal care–there was no plan to control costs. In order to do that the federal government and the provinces were to share the spending, originally on a 50/50 basis. Gradually the federal government has tried to pawn off its share on the provinces, who are now responsible for 70%. Physician services account for only 16% of the costs in Canada. Hospital and capital expenditures are major costs. The system until 1987 was highly inflationary and it was eating up the ability of the country to compete.

Administrative costs are only 1%, for example, in Ontario, indicating you can run a streamlined health system for very low administrative costs. Politicians have used "doctor bashing" and rises in the physician supply for an explanation to the public as to why health care costs are rising in Canada. In Canada, physicians have concluded that a single payer fee for service system is better for them in terms of liberty and earning power than an HMO system.

So, how do physicians deal with the single payer system? In Canada, politicians need someone to talk to and physicians have evolved a system of negotiations and representation where we can "work the deal". In 1950, when socialized medicine came into Canada, the physician groups were against it and the physicians opposed it publicly and lost the support of the public. Then new physicians came in and organizations evolved and government negotiations came in. In all the provinces except Quebec one umbrella group negotiates the contract with the government for the working arrangements for health care. In Quebec, you have separate groups negotiating for primary care doctors and for specialists. In the U.S., you have several organizations that could transform themselves to take on these roles. If you umbrella family physicians and specialists, you have a lot of unity and a lot of force, if you have the right to protest. If the ratio of family physicians to various specialists is out of line in one or the other, the executive representation may not fairly represent the minority. The Quebec model corrects that problem, but it gives the government the opportunity to divide the competing physician groups and make their interests look silly in the public's eyes. I think the Quebec model is best if the primary care physicians and the specialists can come to some unity away from the government bargaining table. All physicians have to belong to the association that's doing the negotiating and physicians show up 100% at meetings to elect representation.

To negotiate successfully you need a global sum of practice costs, then you have to decide on a reasonable pattern of work in a given discipline. The key thing about negotiations is that the final true value that you negotiate in a contract will not reflect the value of the work you're putting in. The fee for the given service in combination with the work rules and the frequency

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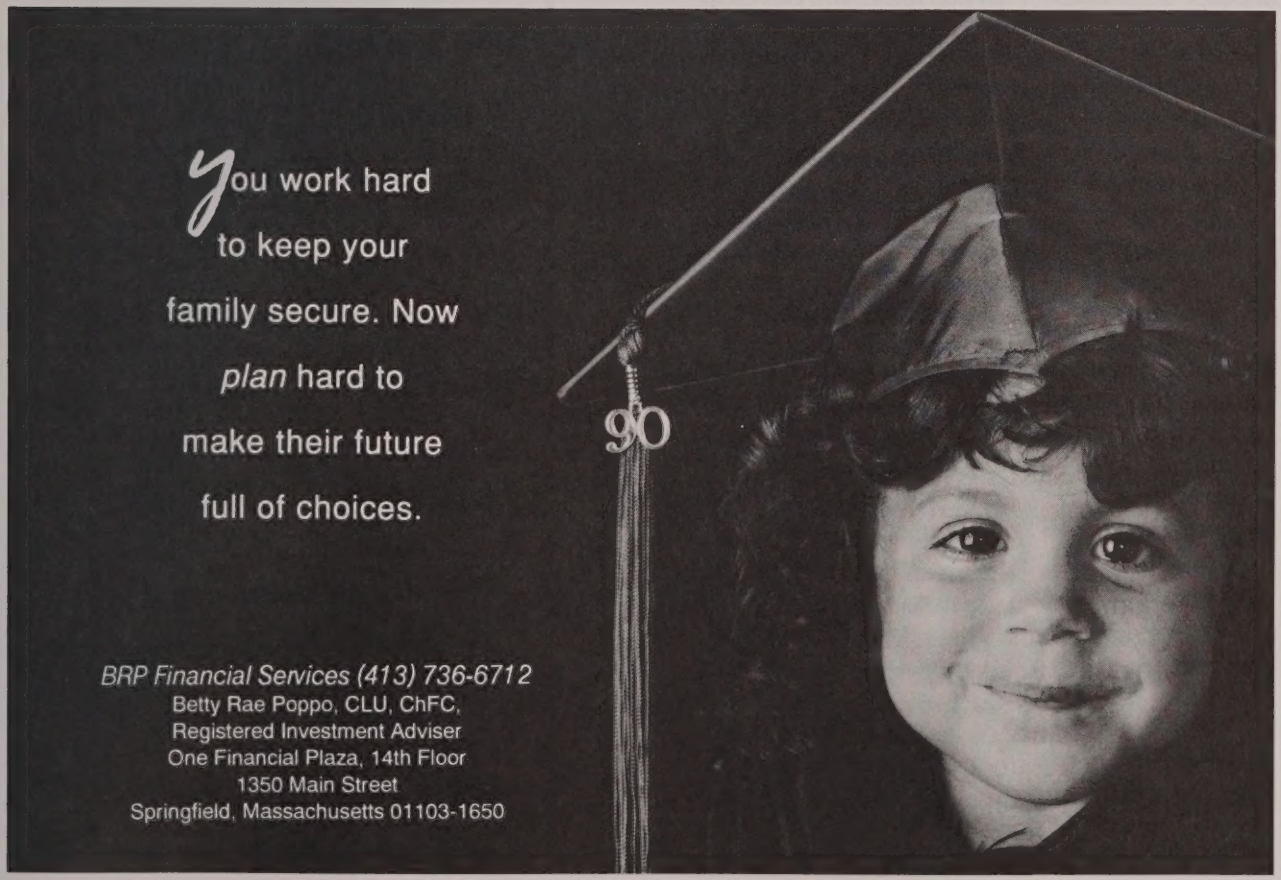

Reform

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that you negotiate determine the final average income. You have to assemble honest profiles of what your practitioners are doing in their daily work in order for your representatives to negotiate successfully. As an example, we negotiated a a contract for general surgeons in which the government wanted a surgical bundle or global fee with no additional charges for 90 days and no malpractice relief. We were united and threatened a round of rotating strikes that could continue indefinitely in the province of Ontario. Ultimately, we got no surgical bundle, a government contribution to malpractice premiums, and a premium for emergency surgery.

The fee schedules are irrelevant. What matters is the total average income. For example the family doctors negotiated a fee for the "principal visit" of $36 in Ontario but only $31 in Quebec. But in Ontario, work rules required that the principal visit for a given patient could only be billed twice a year. In the Quebec contract, there was no limit on principal visits, so in total average income Quebec family physicians did much better subsequently on that contract. Across the country, there is also now a contract clause allowing physicians to bill patients privately for "additional office expenses." This has led to the development of "private centers" for example for ultrasound of the prostate in urology. Our fee of $300 for TURP in Canada seems laughably low to you. But the contract allows billing of $31 for the admission day, plus $13 for any pre-op day, plus $31 for each postoperative day you see the patient. Because of this our average total fee for TURP is actually higher than yours under U.S. Medicare. I'm not promoting the system, because we cannot generate the spread of income you can in the U.S. We have one urologist in Quebec who earns $1 million a year but he works 24 hours a day, seven days a week. Our overhead however is typically only a very small percentage of the gross. Average annual salaries for urologists rose from $140 thousand to $210 thousand under this contract annually. Under socialized medicine, there really is no concept of the work of one specialty being worth more than another or than primary care. Whether a physician is doing cardiac surgery or primary care in the office, all of that work is equally important to the system. To control costs, contracts are renegotiated to limit frequency of services. Hospital beds are limited. New practitioners have to get a

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billing number in order to enter the system. Some provinces have tried to get new graduates to go to underserved areas to receive billing numbers. The issues are similar to the current ones in the U.S.

Physician groups in Canada have developed profiles of their fellow specialist practices as a way of fairly distributing revenue among physicians. The most interesting finding is that the biggest earners and the hardest workers don't abuse the system. The number of abusers of the system is small and they are usually found in the middle income range.

Limiting of income is the current trend across the country. In Nova Scotia, the ceiling for family physicians is $400,000 a year–remember our overheads are very small, usually 25%. If you think you are going to reach your ceiling, you can take a holiday.

Private practice is alive and well in all the provinces except Ontario. In Quebec in urology, we bill patients privately for vasectomy and vasectomy reversal, infertility and impotence evaluation, transtectal ultrasound and other services delivered through our offices. The government welcomes this "private billing" for "quasi-medical" services done outside hospitals because it can't afford to supply it. Blue Cross sells insurance policies to patients to cover it.

The bottom line for physicians is that in Canada in all disciplines in order to make the same revenue you have to work harder. Health care as a right is a political tool that can be manipulated. As a Canadian physician, I advise you to accept whatever system comes, but not as a "sacrificial lamb". You have to make certain that the organizations that represent you are competent, and don't run on their own agendas. In Canada, you have to work through the smoke screen of universal care to decide what you are trying to accomplish, especially as it relates to quasi-medical services. The representatives have to be fully involved and properly trained. Finally we have to have our physician deal with the treatment options in a rational manner. We can't use treatments that are unusually costly because we're penalized ourselves when we do it.

To conclude, the Canadian system is a popular one for our clientele. We can't change it, but we can finesse it. I think we're doing a reasonable, job of that, all things being equal. It's not a system that we're even going to be able to change to conform better to our needs, but it's pretty good for most of us. ■

Edited by Brigid Glackin

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MMS Executive Briefs

It's Official: National Health Reform Pronounced Dead for the Year

After the failure of a last-ditch, off-the-floor effort by a 'mainstream' coalition to agree on a health reform proposal – and faced with little time to restart the legislative process before the November elections – Senate Majority Leader George Mitchell (D-ME) confirmed weeks of rumors and *termed health system reform dead for this session of Congress*. Mitchell, at a Washington DC news conference on September 26, placed the blame for the failure of the health reform effort on Republican "obstructionism" and insurance industry influence. It had become increasingly clear, after the Senate had taken up the crime bill in late August, that Senate leaders could not count on sufficient numbers of Democrats to prevent Republicans from succeeding at promised attempts to block a reform bill. After the announcement, President Clinton pledged to continue efforts towards health system reform.

In a *New York Times* opinion roundup of why health reform failed, opinion ranged from the Clinton administration's desire to fund universal coverage through the employer mandate to partisan politics, unprecedented spending on lobbying and advertising by special interest groups, the complexity of the Clinton plan, and the public's distrust of government, coupled with deep uncertainty about the effects of health system reform on their personal health coverage. P. John Seward, M.D., chairman of the American Medical Association's Board of Trustees, termed the failure of health reform a product of the "complexity" of the health care system and the reform proposals. The AMA also called on Congress to make patient protection its first priority next year and to fix problems in the health care system "that still exist.'

The Massachusetts Medical Society will continue working with the state's Congressional delegation, state legislators, health organizations and the membership to achieve health system reform. The MMS Department of Government Relations will continue to offer its political education/government relations curriculum to districts; the program includes facts of federal/state health reform efforts, physicians' political power, and the impact of elections on health care.

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National Primary Care Day Celebrated

The MMS participated in the celebration of National Primary Care Day on September 29 as more than 140 medical schools around the country held events designed to increase medical student interest in primary care careers. MMS Executive Vice President Harry L. Greene II, M.D., spoke on "Dissecting the Demand: Primary Care and the Medical Profession" before more than 200 medical students, housestaff, and faculty at Boston University School of Medicine.

Doctor Greene, in his Medical Grand Rounds presentation, focused on the need to change the internal and external environments in medicine to increase the numbers of primary care physicians. "We can develop generalist curriculum and expand clerkships to entice students into generalist medicine," Doctor Greene noted, but if students find themselves *"in an external practice environment that is all about capitated fees, gatekeeping, and shutting off patient access to care, all to save money–to deliver dividends, not babies or care, efforts to increase primary care physicians will fail." He called for changes in the practice environment to re-establish physicians' control of the clinical decision-making process and the importance of the physician-patient relationship to health care delivery.* To appropriately meet the nation's demand for primary care physicians, Doctor Greene also called for master planning efforts that emphasize the health needs of the nation, public-private partnerships, all-payor financed graduate medical education, and creation of 'total' incentive packages to attract and retain physicians in primary care careers.

FTC Issues New Guidelines on Antitrust

The Federal Trade Commission (FTC) and the U.S. Department of Justice last week announced guidelines that broaden the definition of allowable physician joint ventures under current antitrust laws. The new FTC guidelines will allow 30 percent (versus the previous 20 percent) of physicians in a specialty within a competitive location to join together to negotiate with health insurers and employers, provided certain other conditions are met. The American Medical Association termed the FTC action "a small step forward" but one that "did not go far enough" in helping physicians to compete in the health care marketplace. ■

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Arrivals

Dr. Ronald Greenwood has joined Drs. Stanley Glaser, Mohan Rao and T.K. Ramen in the practice of pulmonary and internal medicine in Springfield and Chicopee as of September 6, 1994.

Dr. Andrew Moskovitz has joined Springfield Medical Associates for the practice of Adult Medicine and Pediatrics at their new location at 1000 Wilbraham Road in Springfield

Dr. Heidi Moskovitz has joined Dr. Devon Foulks for the practice of obstetrics and gynecology in Springfield, Wilbraham and Holyoke as of October 1, 1994. ■

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Letter To The Editor

26 September 1994

Dear Dr. Glackin

As a sometime TV watcher, I happened to come across the recent prostate cancer program sponsored by the Hampden District Medical Society.

Of course, I saw many familiar faces but also saw a number whom I do not know. All of the physicians spoke extremely well and answered the great variety of questions from the callers with considerable thoughtfulness and obvious expertise. I was able to see most of the urologists present that evening actually answering telephone calls and frankly I was quite impressed with their professionalism and their understanding of the embarrassment and awkwardness which a number of the callers would naturally display. The answers from the urologists were uniformly clear, understandable to the lay person, and handled with respect for the caller.

The Hampden District Medical Society in general, and the fine group of urologists present that evening in particular, did themselves proud. This was first-rate community service!

Samuel J. Brendler, M.D.

New Members Welcome

Jacques H. Blanchet, M.D.
Baystate Medical Center
759 Chestnut Street
Springfield, MA 01199

Born: July 28, 1958
Premed: Providence College, RI 1978-1982
Medical: McGill University, Montreal, Canada 1982-1986
Internship: Jewish General Hospital, Canada 1982-1983
Residency: Jewish General Hospital, Canada 1983-1985 (Family Practice)
Denver General Hospital, Colorado 1991-1994 (Emergency Medicine)
Specialty: Emergency Medicine/Family Medicine

Jonathan L. Klatt, M.D.
Baystate Medical Center
759 Chestnut Street
Springfield, MA 01199

Born: October 28, 1967
Premed: Carroll College, Wisconsin 1985-1989
Medical: Medical College of Wisconsin 1989-1993
Internship: St. Luke's Medical Center, Wisconsin 1993-1994
Residence: Baystate Medical Center 1994-Present
Specialty: Anesthesiology
Resident

Margaret L. Klatt, M.D.
Baystate Medical Center
759 Chestnut Street
Springfield, MA 01199

Born: October 15, 1966
Premed: Mt. Mary College, Wisconsin 1985-1989
Medical: Medical College of Wisconsin, 1990-1994
Internship: Baystate Medical Center 1994-Present
Specialty: Anesthesiology
Intern

Paul C. Lin, M.D.
Baystate Medical Center
759 Chestnut Street
Springfield, MA 01199

Born: February 26, 1968
Premed: Columbia College, New York 1986-1990
Medical: Albany Medical College, New York 1990-1994
Internship: Baystate Medical Center 1994-Present
Specialty: Obstetrics/Gynecology
Intern

Mitchell H. Kaufman, M.D.
130 Maple Street #302
Springfield, MA 01103

Born: January 6, 1958
Premed: UCLA, California 1975-1979
Medical: St. George's University, Grenada, West Indies 1980-1982
UCLA, California 1982-1984
Internship: West Los Angeles VA Medical Center 1984-1985
Residency: West Los Angeles VA Medical Center 1985-1988
Specialty: Neurology

John R. Kelley, M.D.
2341 Boston Road
Wilbraham, MA 01095

Born: December 30, 1960
Premed: Georgetown University 1979-1983
Medical: University of Washington School of Medicine 1983-1987
Internship: Strong Memorial Hospital–University of Rochester 1987-1990
Residency: Strong Memorial Hospital 1987-1990
Fellowship: Yale-New Haven Hospital, CT 1990-1993
Specialty: Pediatrics/Pediatric Cardiology

Continued on next page

New Members Welcome

Continued from previous page

Steven L. Lyndaker, M.D.
2377 Boston Road
Wilbraham, MA 01095

Born: November 15, 1963
Premed: Hamilton College, New York 1982-1986
Medical: University of Rochester School of Medicine 1986-1990
Internship: Strong Memorial Hospital 1990-1991
Residency: Strong Memorial Hospital 1991-1993
The Genesee Hospital 1993-1994 (Chief Resident)
Specialty: Internal Medicine

Heidi F. Moskovitz, M.D.
91 School Street
Springfield, MA 01105

Born: August 5, 1963
Premed: State University of New York, Buffalo 1981-1983
State University of New York, Syracuse 1983-1985
Medical: New York Medical College, Valhalla, NY 1986-1988
State University of New York, Syracuse 1988-1990
Internship: Baystate Medical Center 1990-1991
Residency: Baystate Medical Center 1991-1994
Specialty: Obstetrics/Gynecology

David K. Winsemius, M.D.
Mass Mutual
1295 State Street
Springfield, MA 01111

Born: January 24, 1949
Premed: University of Michigan 1967-1969
University of California, Berkley 1969-1971
Medical: University of California School of Medicine, Davis 1972-1976
Internship: Stanislaus Medical Center (Formerly Scenic General Hospital) Modesto, CA 1977-1978
Residency: Stanislaus Medical Center, CA 1978-1980
Fellowship: University of Washington-Dept. of Family Practice 1985-1987
Specialty: Family Practice

Kathleen L. Meade, M.D.
260 Ludlow Road
Chicopee, MA 01020

Born: May 20, 1956
Premed: Manhattanville College 1974-1975
Ramapo College of New Jersey 1983-1985
Medical: UMDNJ–New Jersey Medical School 1986-1990
Internship: UConn Health Center, Farmington, CT 1990-1991
Residency: UConn Health Center 1991-1994
Specialty: Internal Medicine

Asha Sindwani, M.D.
77 Winsor Street
Ludlow, MA 01056

Born: September 1, 1948
Premed: Hindu College, Delhi, India 1965-1966
Medical: H.P. Medical College, Simla 1966-1972 (Indira Gandhi Medical College)
Internship: Jewish Hospital, Cincinnati, Ohio 1972-1973
Residency: Philadelphia General Hospital, PA 1973-1974
St. Vincent's Hospital, Worcester, MA 1975-1976
Specialty: Pediatrics

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